Retention of Licensed Professional Services

Proposal
January 2005

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Executive Summary

The purpose of this paper is to present a recommendation for the transition of some licensed professional services currently offered at the Fircrest School to the community. This proposal was developed in anticipation of a possible decision by the 2005 Legislature to close Fircrest School during the 2005-2007 biennium as provided for in the budget submitted by former Governor Gary Locke in December 2004.

A work team was convened in the fall of 2003 to develop a recommendation for the transition of licensed professionals should Fircrest close. The work team was comprised of staff of the Division of Developmental Disabilities (DDD) and included licensed professionals from Fircrest and Rainier Schools and members of the Fircrest Downsizing Project Support Unit. This team developed several options and made a recommendation that was later modified to be aligned with Governor Gary Locke's budget. The requirements for this proposal were to first assess demand for licensed professional services in the community and then to base the proposal on the findings on the following desired outcomes:

1. provide outreach and consulting services
2. maximize statewide access
3. assist with building community resources for licensed professional services
4. provide some level of direct care.

In assessing demand, several gaps in services were found for dental services, assistive technology (especially for augmented communication and environmental control), mobility (especially wheelchair adaptation and modification), and behavior management. This proposal is consistent with the assessment of demand except for the behavioral component that is being addressed separately by DDD.

The proposal is to provide consultative services emphasizing outreach, access, and consulting while providing direct care for dental, assistive technology, and wheelchair services. The focus for the proposal is to build skills in community service providers (both professional and residential) and provide access to relevant specialized information as a means to improve both service access and levels of care to individuals with developmental disabilities. Consultative services would be comprised of a team of nine professionals and staff at a biennial budget of $2.1 million. This staff would provide both in-house and mobile direct care to approximately 3400 DDD clients annually in furtherance of its mission of educating and building community resources.

Introduction

Legislative Authority

The 2003 Legislature asked DSHS to "Provide a preliminary transition plan to the fiscal and policy committees ...The transition plan shall include recommendations on ways to continue to provide some of the licensed professional services offered at Fircrest School to clients being served in community settings" Chapter 211(e), Laws of 2003, 1st Special Session (2003-05 operating budget). The purpose of the licensed professional services offered at Fircrest School is to provide medical, dental, behavioral, therapies and other professional services to its residents. Appendix 3.2.A contains the operating budget language specific to licensed professional services.

Purpose

The purpose of this document is to provide recommendations to transition some of the licensed professional services at Fircrest School to serve clients in community settings. This paper includes a recommendation for the retention of selected services, along with alternatives. Financial parameters for the recommendation were not initially provided with the legislative language. Therefore, it was assumed that any proposed recommendation would need to be carefully reviewed and modified to appropriately align with budget constraints.

The original recommendation and alternatives provided in this document precede the announcement of Governor Gregoire's budget proposal for the 2005-07 biennium. As required by law, Governor Gregoire's budget proposal will replace the budget proposal submitted by former Governor Locke, released on December 16, 2004. Given the time constraints related to releasing a budget for the 2005-07 biennium and the potential impact on licensed professional services, a modified proposal that meets the parameters provided in Governor Locke's budget was developed. When the budget proposal for the 2005-07 biennium is released by Governor Gregoire, this proposal should be reviewed and modified as appropriate.

Background

Nationwide, the number of individuals with developmental disabilities living in state-operated institutions has declined steadily since the 1970's. From 1990-2002, the number of residents of public and private institutions declined 39%, from 176,036 to 106,893 persons.[1] Most of this change was accounted for by public institutions which declined from 84,818 to 44,252 persons, a 48% decrease. The numbers of

[1] Mary C. Rizzolo, Richard Hemp, David Braddock, Amy Pomeranz-Essley, *The State Of The States Developmental Disabilities,* Department of Psychiatry and Coleman Institute for Cognitive Disabilities, The University of Colorado, American Association on Mental Retardation, Washington, D. C. , 2004

private institutional residents in facilities for sixteen or more persons declined 30%, while the number of nursing facility residents declined by 31%.

Fircrest School in Seattle followed the national trend, expanding in the decade of the 1960s and then reducing its population during the decade of the seventies and subsequent decades. Like other residential habilitation centers (RHCs), Fircrest provides residents with three basic types of services: 1) residential support services e.g., direct care staff to assist with activities of daily living, housing and food preparation; 2) vocational support services e.g., adapted work activities and job coaching; and 3) professional services e.g., services of physicians, dentists, nurses, speech pathologists, therapists, and others.

Historically, clients leaving Fircrest School and other RHCs were more often those who were the least impaired and did not require special services. In many cases, these clients only required vocational services. Existing facilities in the community, such as sheltered workshops, expanded and entirely new agencies were created to meet the growing vocational service needs. The typical goal of vocational agencies today is to develop job sites that are integrated into community settings such as restaurants, hotels, offices and industrial sites.

As individuals left Fircrest and other institutions, the need for community-based services increased. Initially these needs were met by contracted residential service agencies operating group homes in residential neighborhoods. Now these services are more often provided in individualized settings such as apartments and homes that are more integrated with the local community. Today the majority of individuals with developmental disabilities are supported in the family home or in other integrated community settings. However as documented in this proposal, some professional services can be more difficult to access in the community and at times must be met in other ways, such as more costly emergency room visits or hospital stays. Utilization of these more expensive services is understandable in instances where emergencies arise, but it a cause for concern if such utilization is regularly attributable to difficulties in accessing preventive care.

Accessing Services in the Community

One potential obstacle to accessing services in the community is the increasing practice among some providers to limit the number of Medicaid clients they will serve. A recent survey of medical assistance providers in this state found that 70% of dentist, 50% of primary care providers, and 32% of specialty care providers restricted the number of Medicaid clients they served[2]. Moreover, these percentages reflected responses from current Medicaid providers and did not include providers who refuse to take Medicaid clients under any circumstance or current providers who are intending to begin limiting services.

A lack of qualified service providers is also a significant obstacle to the delivery of services to people with co-existing conditions[3]. A recent study[4], using national data, took a more detailed look at (a) long term support, (b) program planning and case management, (c) clinical consultation and treatment, (d) psychiatric or medication management, (e) crisis intervention, (f) short term inpatient psychiatric care,

[2] Raiha, N. K. July, 2004 *Medical Assistance Provider Study*, Washington State Department of Social and Health Services, Research and Data Analysis Fact Sheet Number 11, 108h.

[3] Co–existing conditions are when a client has two or more simultaneous diagnoses.

[4] Prouty, R. W., Smith, G. & Lakin, K. C. (Eds.) (2004). Executive Summary. Residential services for persons with developmental disabilities: Status and trends through 2003. Minneapolis: University of Minnesota, Research and Training Center on community Living, Institute on Community Integration.

and (g) trained staff. This study concluded that an insufficient number of qualified service providers in any of these areas can significantly impair service delivery. Moreover, when state directors of developmental disabilities and mental health agencies were then asked to rank order obstacles to supporting individuals with co-existing conditions, they identified the following:

1. Not enough providers
2. Provider unwillingness
3. Lack of coordination
4. System structure
5. Lack of targeted funds

In Western Washington there are organizations which do provide some services to individuals with developmental disabilities. These include Provail, a former affiliate of United Cerebral Palsy, hospitals such as the University of Washington Medical Center and some private practices. However, many other providers lack the capacity to meet the complicated needs of these individuals. Several facilities see people only for acute needs and only on a limited basis. They are unable to meet the ongoing changing equipment; staff training, behavioral and physical needs of persons with DD. In addition, persons with developmental disabilities often require a much longer period of rehabilitation and often are discharged before completing rehab because they don't meet standards of progress, or have behavior that is unacceptable in the setting. Also many professionals lack skills of interaction with individuals with developmental disabilities or communication challenges and are uncomfortable serving them.

Medicaid reimbursement rates are low, providers are often difficult to find, and third party payers almost never pay for care coordination activities that are crucial to providing adequate care to persons with developmental disabilities. Knowing they cannot ensure that their patients with developmental disabilities receive the coordinated intervention from several professional disciplines they need for adequate care, many providers avoid serving patients whose developmental disabilities cause them to have complex medical problems or greatly impaired verbal skills.

Nationally, individuals who continue to live in the institutions are, for the most part, those with co-existing conditions in addition to mental retardation. At least 47% of current institutional residents have two or more sensory, neurological or behavior conditions and 37% are unable to walk without assistance (see footnote 4 below). Thus as deinstitutionalization trends continue, there will be a growing number of individuals with developmental disabilities requiring specialized community-based services for sensory, neurological, behavioral and orthopedic conditions. That is not to say that individuals in the community do not share these same co-existing conditions. As institutions have downsized, there are fewer differences between those living in RHCs and those living in the community.

The Impact on Individuals with Developmental Disabilities of Licensed Professional Services in the Community

Access to medical services for individuals with developmental disabilities will continue to be an issue for the foreseeable future, just as it will for other groups of people who do not have developmental disabilities. In most cases adult individuals with developmental disabilities or their guardians are eligible for and are enrolled in Medicaid. Most can find needed services although communication, behavioral and mobility challenges add a level of complexity to both finding and receiving services for some. The current shortage of providers who are skilled in treating individuals with co-existing conditions and who are willing and able to coordinate these services complicates access to care.

At the 2002 Surgeon General's Conference[5], the most pressing needs of people with mental retardation were identified. There were six areas of focus identified on a national level that are directly relevant to the needs of individuals living in the community in the State of Washington. These areas include:

GOAL 1: Integrate health promotion into community environments of people with mental retardation

GOAL 2: Increase knowledge and understanding of health and mental retardation, ensuring that knowledge is made practical and easy to use

GOAL 3: Improve the Quality of health care for people with mental retardation

GOAL 4: Train health care providers in the care of adults and children with mental retardation

GOAL 5: Ensure that health care financing produces good health outcomes for adults and children with mental retardation

GOAL 6: Increase sources of health care services for adults, adolescents, and children with mental retardation, ensuring that health care is easily accessible for them

Approach

In the fall of 2003 a team of professionals from Fircrest School and from DSHS's Aging and Disability Services Administration (ADSA) was formed to consider how to retain some of the highly specialized and licensed professional services located at Fircrest School to serve the needs of persons with developmental disabilities in the community, and to identify steps to accomplish this goal. Current licensed professional services at Fircrest School include dental services, medical and nursing services, psychology and behavioral services, and rehabilitative services (including assistive technology, speech pathology, audiology, physical therapy, occupational therapy, and wheelchair repair/adaptation) all of which now provide a modest level of services to persons living in the community. The focus of the team was to determine which if any of the licensed professional services that are part of Fircrest School can be maintained in the future as services that can be provided in the community.

[5] CLOSING THE GAP: *A National Blueprint to Improve the Health of Persons with Mental Retardation, 2002,* Report of the Surgeon General's Conference on Health Disparities and Mental Retardation

The approach the team used was to gather information from a variety of sources to examine successes and lessons learned from other states (literature review and telephone interviews), as well as collect data from local stakeholders (interviews and other invited input), from relevant state databases, and the experiences from licensed professionals who are currently providing these services.

The diverse base of stakeholders for this work included the following groups and individuals:

1. Individuals with developmental disabilities – individuals currently living in the community who have developmental disabilities.
2. Community providers – professionals in the community who currently provide or have an interest in developing the knowledge and skills to effectively provide services to DDD clients.
3. Academic institutions and professionals in training – graduate students in programs with internship agreements
4. Residential providers – community residential provider contractors
5. Advocate groups – groups of individuals with a common shared interest in people with developmental disabilities including families and parents
6. Government agencies and service providers – federal, state, and county service providers and funding sources

The approach included development and documentation of the following sections.

- Defining demand
- Proposal
- Comparisons between models

Defining Demand

For purposes of this study, demand was operationally defined as need *minus* capacity. Demand was not directly measured for this proposal since neither need nor capacity could be reliably assessed at this time. Instead, demand was estimated from several sources including:

1. National Core Indicator Study (NCIS)
2. Medical Assistance Administration (MAA) data
3. Supports Intensity Scale (SIS) Data
4. Invited input sessions
5. Other patterns based on best practices

National Core Indicator Study (NCIS)[6]

Method: Questions about medical care provided to community residents were added to the 2004 National Core Indicator Study conducted by the State of Washington. These items addressed whether specific services were needed for the DDD clients in the survey, whether the client was receiving services (and if not why), whether the services were adequate, whether the professional was knowledgeable, and whether the professionals communicate with each other. Two surveys were administered[7]:

1. Adult Family Survey – The State of Washington administered the Adult Family Survey by selecting a random sample of 1,520 families who: a) have an adult family member with developmental disabilities *living at home*, and b) receive service coordination and at least one additional "direct" service or support. Adults were defined as individuals with disabilities age 18 or older. Approximately 3500 families met the selection criteria. Of the 1,520 surveys sent, 580 usable surveys were received.

2. Family and Guardian Survey – The State of Washington administered the Family Guardian Survey by selecting a random sample of 1,505 families who: a) have an adult family member with developmental disabilities *living outside of the family home*, and b) receive service coordination and at least one additional "direct" service or support. Adults were defined as individuals with disabilities age 18 or older. Approximately 8600 families met the selection criteria. Of the 1,505 surveys sent, 662 usable surveys were received.

The data were summarized overall in terms of level of need across clients regardless of their residence. Comparisons were then made between clients residing in their family home or in the community and by target population.

Results: In the State of Washington, 63% of DDD clients live at home[8]. Across the board, those responding to the Family and Guardian Survey (clients living in the community) perceived their medical care more positively than those responding to the Adult Family Survey (clients living in parental or relatives home). This result was likewise found in the larger (national) study and may be explained by the real and perceived differences in funding between these two programs as well as the more enhanced quality assurance programs addressing community providers that monitor and require more regular medical oversight.

Overall, survey respondents for individuals living at home said they had a regular doctor and dentist significantly less frequently than respondents for individuals living outside the home. The help received was also viewed as somewhat less adequate for dental services for individuals living in their family home. Both doctors and dentists were also viewed as less knowledgeable about working with individuals with developmental disabilities by those responding to the Adult Family Survey (see Figure 1 below). As a basis of comparison, the 2003 national survey results from the American Dental Association shows that

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[6] "The National Core Indicators is collaboration among participating NASDDDS member state agencies and HSRI, with the goal of developing a systematic approach to performance and outcome measurement. Through the collaboration, participating states pool their resources and knowledge to create performance monitoring systems, identify common performance indicators, work out comparable data collection strategies, and share results." http://www.hsri.org/nci/

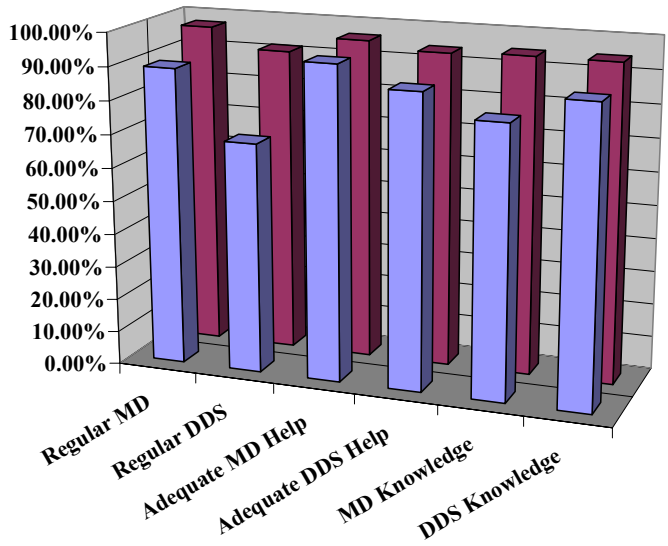
[7] For a more complete explanation of the survey methodology or copy of the report, contact Lisa Weber, PhD, senior researcher, (360) 725-3411, or weberla@dshs.wa.gov

[8] Data extracted from CCDB residential summary Nov 2004 by combining people living at parent's home and relative's home (19,141 living in parents home; 1,425 living in relative's home for a total of 20,566). and divide by the total number of clients (20,566/32,647 = 63%).

82.2% of the general population has a regular dentist; in comparison, 69% of DDD clients living in the family home and 91.5% living outside the family home reported they had a regular dentist[9].

Medical services for behavior, communication, chewing/swallowing, memory and mobility challenges were also examined. Overall, communication challenges were the most frequently mentioned, followed by behavioral, chewing/swallowing, mobility, and memory challenges. Significantly fewer individuals living in their family home were reported to have behavioral or communication challenges even though these were issues of concern overall. The reverse was true for chewing/swallowing, where significantly more issues were reported for those living in the family home. These results are shown in Figure 2 on the next page.

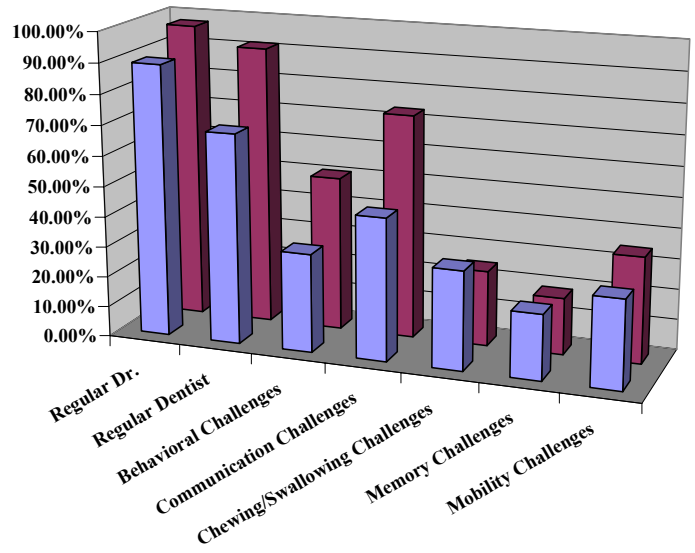
Figure 1
Medical and Dental Services



	Regular MD	Regular DDS	Adequate MD Help	Adequate DDS Help	MD Knowledge	DDS Knowledge
Living in Family Home	89.30%	69.00%	93.84%	87.69%	80.90%	88.50%
Living Outside Family Home	97.33%	91.49%	96.26%	94.11%	94.80%	94.72%

[9] http://www2.cdc.gov/nohss/ListV.asp?qkey=2

Figure 2
All Medical Services



	Regular Dr.	Regular Dentist	Behavioral Challenges	Communication Challenges	Chewing/Swallowing Challenges	Memory Challenges	Mobility Challenges
Living in Family Home	89.30%	69.00%	32.38%	46.63%	32.38%	21.40%	29.05%
Living Outside Family Home	97.33%	91.49%	50.69%	73.39%	24.75%	18.65%	34.78%

A final analysis of individuals most closely resembling the target population was also conducted. These groupings were determined by responses to associated demographic items in the NCIS Surveys. The three groupings most closely representing the target population included:

1. Individuals who were identified as either severely or profoundly mentally retarded.
2. Those who reported being diagnosed as mentally retarded and/or autistic.
3. Individuals who require either onsite or line-of-sight care.

The data in Table 1 below shows a similar pattern to the overall survey results discussed above. There are significant differences between family and community residents for all special populations reporting for

1. having a regular dentist (higher for community residents)
2. having behavioral challenges (higher for community residents)
3. having care coordinated between professionals (higher for community residents)
4. having communication problems for individuals with either severe or profound mental retardation (higher for community residents)

Table 1
Services and Challenges for Target Populations

	TARGET POPULATIONS					
	Severe/Profound		***MR/Autism***		***Onsite/Line-of-Sight***	
	Family N= 107	**Community N=228**	**Family N=145**	**Community N=174**	**Family N=197**	**Community N=318**
Regular Dr.	96.00%	98.09%	94.70%	96.97%	94.68%	98.29%
Regular Dentist	*69.70%*	*92.12%*	*74.05%*	*90.18%*	*75.14%*	*91.58%*
Medical Challenges						
Behavioral	*30.21%*	*59.11%*	*50.76%*	*77.64%*	*38.67%*	*58.89%*
Communication	*69.70%*	*87.63%*	73.08%	75.16%	73.74%	82.50%
Chewing/Swallowing	40.20%	41.90%	26.24%	18.56%	38.86%	34.45%
Memory	24.42%	27.17%	25.76%	24.00%	27.44%	26.85%
Mobility	50.98%	56.65%	19.86%	25.30%	50.53%	54.01%
Professionals Coordinate Care	*57.14%*	*89.67%*	*43.28%*	*79.75%*	*50.28%*	*84.75%*

Note: Italicized services indicate significant differences between clients living at home and those living in the community.

Although a high percentage of clients in both parental home and community residences responded that they had behavioral or communication challenges, when asked if they were receiving help, those living at home responded that they were receiving less help than those living outside the family home (see Table 2).

Table 2
Respondents Receiving Help

	RECEIVING HELP			
	Living in Family Home		**Living Outside Family Home**	
	# People	**Percentage**	**# People**	**Percentage**
Behavioral Challenges	91	*41.74%*	247	*78.41%*
Communication Challenges	88	*15.17%*	261	*65.41%*
Chewing/Swallowing Challenges	91	*41.74%*	85	*61.59%*
Memory Challenges	30	*23.81%*	63	*52.07%*
Mobility Challenges	64	*36.78%*	187	*87.38%*

Note: Italicized services indicate significant differences between clients living at home and those living in the community.

This same pattern is likewise shown regarding whether the help was adequate and whether the professional was perceived as knowledgeable (See Table 3). In Table 3, both medical and dental help were generally perceived as adequate and the professional as knowledgeable. When asked the same questions about behavior, communication, chewing/swallowing, memory and mobility challenges, most respondents (76-81%) felt the help they were receiving was adequate. Although there were significant differences between those living in their family home and those living in a community residence, the family home respondents were consistently less satisfied with services.

Table 3
Respondents Perception of Adequacy of Help and Knowledgeable Professionals

	HELP ADEQUATE				KNOWLEDGEABLE PROFESSIONAL			
	Living in Family Home		Living Outside Family Home		Living in Family Home		Living Outside Family Home	
	# People	Percent Agreeing	# People	Percent Agreeing	# People	Percent Agreeing	# People	Percent Agreeing
Regular Dr.	472	94%	541	96%	432	81%	510	95%
Regular Dentist	413	88%	495	94%	400	88%	466	95%
Behavioral Challenges	125	*80%*	262	*93%*	117	*84%*	256	*96%*
Communication Challenges	124	*78%*	294	*90%*	111	*69%*	270	*96%*
Chewing/Swallowing Challenges	65	*79%*	128	*93%*	53	*74%*	118	*94%*
Memory Challenges	51	*76%*	87	*89%*	46	*75%*	84	*93%*
Mobility Challenges	90	*81%*	199	*96%*	78	*83%*	173	*93%*

Medical Assistance Administration (MAA) Data

Methods:

1. High Use Clients – This study group includes DDD clients aged 21+ who did not receive RHC services and either (1) received ADSA nursing home services or (2) had total expenditures on ADSA in-home services + DDD personal care services in the top 10th percentile. The 90th percentile annual expenditure for ADSA in-home Services + DDD personal care services was $17,042.
2. 2001-2003 MAA data - This data represents a summary of all the medical services paid by MAA during calendar years 2001-2003 for adult DDD community clients in the catchment area (Snohomish, King, and Pierce counties). These counties were included since they represent approximately 48% of the total number of DDD clients statewide and would also be within reasonable (one hour) commuting distance to potential sites for a clinic. Current Procedural Terminology[10] (CPT) codes representing the medical procedures to be offered in the integrated model were identified by the team members and used to focus the search.

Results:

1. Table 4 below shows state medical services provided to the high use clients in these three counties. Medical services data is shown for: Division of Developmental Disabilities (DDD), Division of Vocational Rehabilitation (DVR), and Medical Assistance Administration (MAA). The DDD, DVR, MAA totals represent all DDD clients who match the criteria for this population (defined above) and the number and per cent served indicate the actual utilization of these services during this three year period. Definitions for each of the services are shown in Appendix 3.2.B. These data indicate that from 2001-2003, 96-97% of these high use clients were funded for prescription drugs, 83-86% were funded for other services (these include durable medical equipment and home health care among other services), 74-79% were funded for physician's services, and 55-59% were funded for personal care (which includes semi-skilled maintenance and supportive services).

[10] CPT codes are five-digit numbers used to represent the universe of medical and psychiatric services given to patients

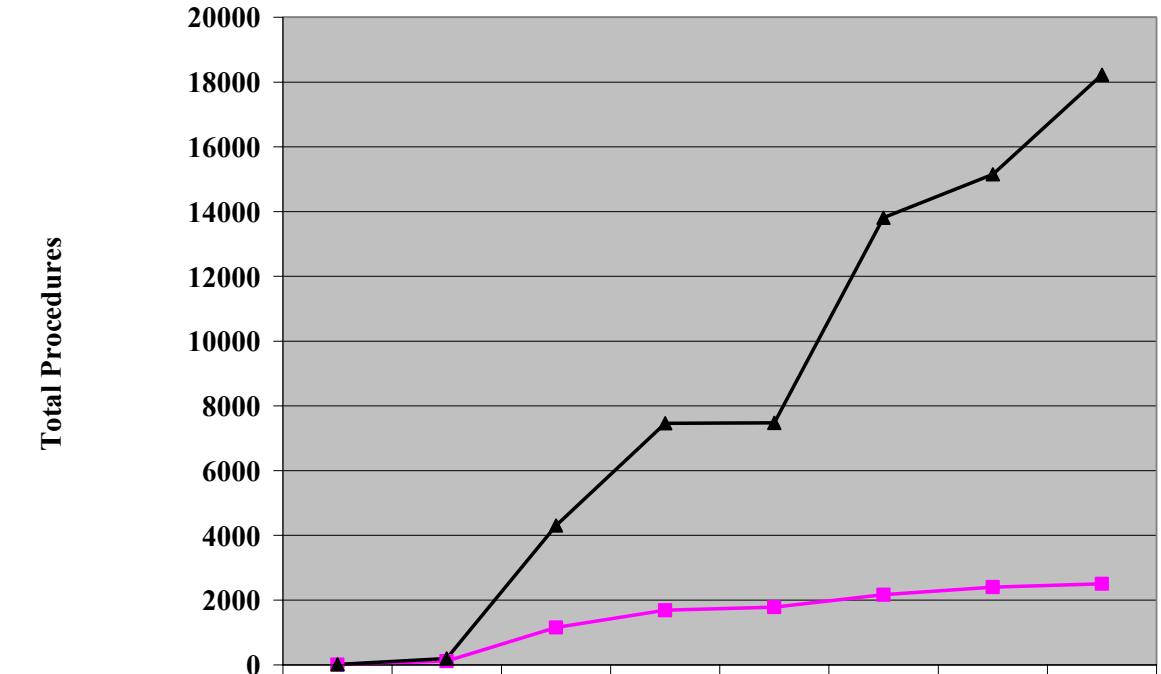
Table 4
State Services Provided to DDD Clients in Snohomish, King, and Pierce Counties
2001-2003

	2001			2002			2003		
	# Served	**% Served**	**Tot Spent**	**# Served**	**% Served**	**Tot Spent**	**# Served**	**% Served**	**Tot Spent**
DDD Total	**1,110**	**100.0%**	**$17,704,242**	**1,146**	**100.0%**	**$20,478,529**	**1,194**	**100.0%**	**$22,544,867**
Personal Care	609	54.9%	$10,770,628	670	58.5%	$12,966,652	703	58.9%	$14,193,182
Professional Support Service	264	23.8%	$85,509	260	22.7%	$94,404	281	23.5%	$94,759
DVR Total	**85**	**7.7%**	**$196,429**	**79**	**6.9%**	**$186,566**	**78**	**6.5%**	**$213,196**
Medical/Psychological Service	12	1.1%	$19,254	8	0.7%	$9,453	8	0.7%	$20,636
MAA Total	**1,107**	**99.7%**	**$8,322,393**	**1,142**	**99.7%**	**$9,695,933**	**1,193**	**99.9%**	**$9,539,229**
Dental Services	436	39.3%	$108,178	439	38.3%	$92,832	501	42.0%	$110,090
Hospital Inpatient	207	18.6%	$1,945,884	218	19.0%	$2,169,500	229	19.2%	$1,373,644
Hospital Outpatient	530	47.7%	$425,999	548	47.8%	$390,305	583	48.8%	$449,140
Other Services	922	83.1%	$2,461,637	993	86.6%	$3,027,488	1,033	86.5%	$3,342,112
Physicians Service	881	79.4%	$319,094	909	79.3%	$386,084	882	73.9%	$264,665
Prescription Drugs	1,069	96.3%	$3,061,600	1,108	96.7%	$3,627,427	1,163	97.4%	$3,997,056

2. Service utilization is another estimate of demand. The following MAA data that follows provides an overview of actual utilization of services that were reimbursed during calendar years 2001-2003. Figure 3 below shows the total number of procedures and adult clients served from 1996-2003 in the three county catchment area. Three years of data from calendar years 2001-2003 were included in all subsequent results due to changes in reimbursements for dental services beginning in 2001. Overall, these data show annual increases in both the number of clients served and number of procedures performed.

   Figure 4 below shows that for the 2884 total unique clients for this three year period and 47183 total procedures, clients averaged 5.5 procedures per year with a range from 1 procedure to 92 procedures annually. The breakdown of medical service utilization for the top 95% of procedures shown in Table 5 indicates that the most frequently accessed services were dental and medical followed by psychology, physical therapy and speech therapy. Appendix 3.2.C data shows the frequency of procedures during 2001-2003 for the top 80%, 90%, and 95% of procedures performed.

Figure 3
MAA Data of Number of Procedures and Clients Served
Adults in Snohomish, King, and Pierce counties
1996-2003



	1996	1997	1998	1999	2000	2001	2002	2003
# Unique Clients	9	118	1152	1683	1782	2168	2401	2502
Total Procedures	14	195	4302	7461	7477	13807	15149	18227

Figure 4
Frequency of Procedures by Client
2001-2003

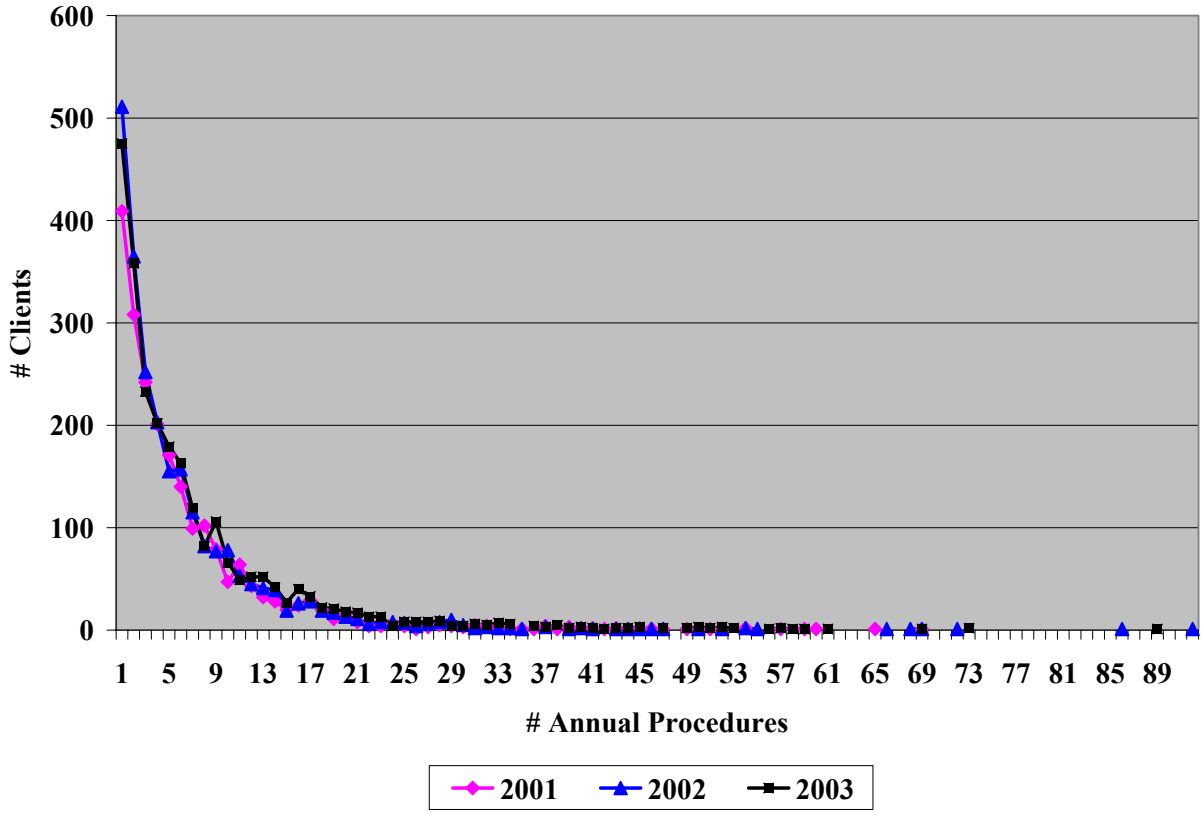


Table 5
Most Frequent Procedure Types – Top 95% of All Procedures
2001-2003

Type of Medical Service	Frequency among the Top 95% of Procedures	Percent of Total* Procedures
Dental	19618	42%
Medical	18186	39%
Psychology	3747	8%
Physical Therapy	3212	7%
Speech Therapy	1174	2%

*These percentages do not sum to 95% due to rounding.

Supports Intensity Scale (SIS) Data

Method: In June of 2004 the Assistive Technology and Treatment Center (ATTC) at Fircrest School had approximately 200 active community clients. Of these, twenty were chosen randomly to be described with the Supports Intensity Scale (SIS). The SIS was administered via a telephone interview with the client's current caregiver. This was seen as the most efficient way of describing the ATTC client population as a whole.

The SIS scores produced two distinct groups. The first group had fifteen members, and was made up exclusively of clients who had been referred to receive adaptive equipment or for management of swallowing disorders. The second group had four members and was referred for the evaluation and treatment of age related impairments such as Alzheimer's dementia. The first group was slightly above average on all scales. This means that they need more support services than is typical of clients that are eligible for DDD services. The second group was far below average on all scales, meaning that they tend to need much less in the way of support services than typical clients. Finally, over 80% of all of the clients had above average needs for special medical or behavioral support services.

Result: The results of this description of ATTC clients suggest why they were unable to receive services from other providers. First, the majority had complex medical or behavioral needs that tend to require the expertise of interdisciplinary teams that are typically not available elsewhere. Next, the first group had greater support needs. They tend to need highly specialized assistive technology and adaptive equipment. In addition, other studies have found that clients with greater needs face more barriers to health care than more typical clients. Finally, the second group presented problems stemming from the combination of age related impairments and developmental disabilities. Most providers have little or no experience with this combination of disorders.

Invited Input Sessions

Method: The Fircrest Downsizing/RHC Consolidation Project Support Unit conducted invited input sessions in conjunction with DDD Region 4. Participating in the invited input sessions were people with developmental disabilities, DDD case resource managers, parents and guardians, advocate groups, residential providers, employment venders, university and hospital representatives, and King County service providers. In addition, several retention of licensed professional services team members also attended each session to answer specific technical questions.

Results: The participants in the invited input sessions provided valuable feedback about community services. Several general themes concerning obstacles to access were consistent across groups and individuals. This included a lack of knowledge about how to serve people with developmental disabilities and limited number of providers who accept Medicaid.

With regard to specific services, behavioral support and mental health providers were perceived to be in extreme demand due to large turnover rates and an increased load of clients in the community. Case resource managers reported that some clients must show very significant acute symptoms of mental illness or challenging behaviors before mental health professionals will treat them. Perhaps the largest area of expressed need was for wheelchair providers. There is a large demand indicated for maintenance,

repairs, or new orders for wheelchairs. Current wheelchair providers are unable to fulfill the demand in a timely and appropriate manner. The same is true of PT/OT therapists, nutritionists, doctors, and dentists.

These participants also believed that community services could be improved with additional education of health care providers and improved reimbursement rates.

Other Patterns based on Best Practices

The utilization data for demand has limitations. It is only a part of the picture, showing what is authorized, but not what is needed. Another way to look at demand is the community's ability to provide what would be considered standard or best practice services to existing community residents. For example, it is an accepted dental practice standard that all patients have routine cleanings twice a year. Routine cleanings indicate that the patient has a relatively healthy mouth. If this is not the case and the patient has periodontal disease, then more extensive procedures are required such as root planing followed by 3-4 additional procedures annually. If patients with developmental disabilities are assumed to have healthy mouths (in fact this population has a much higher incidence of periodontal disease) then they would be expected to have two cleanings a year. There are approximately 8,000 adults with developmental disabilities in the three county catchment area so if they were getting the standard of care the utilization data should show 16,000 cleanings each year.

The actual MAA numbers for routine cleanings for adults with developmental disabilities during a three year period were 1482 and for the more extensive procedures (root planing) was 4506. While comparative information for all other adult MAA clients in the catchment is not currently available, these numbers for developmental disabilities clients are low. This information when combined with perceptions of need and barriers to service show a more complete picture. Clearly there is a gap between dental health services delivery for people with developmental disabilities, and the demand for services even taking into account that some procedures are paid through DDD, private insurance and other sources.

Summary of Findings on Demand

Each of the studies above examined demand for services using different methods. Conclusions about this data can be drawn by looking for common themes and explaining results by combining several studies. For example, the NCIS study and the invited input sessions used different methods (survey vs. group input), but had similar type of respondents. Both the NCIS survey and invited input sessions obtained data from parents/guardians. The common theme is that families have a more difficult time accessing medical care for their adult children. In relative terms, the services that are most in demand were communication, behavioral, and mobility services. For those participating in the invited input sessions, the services most needed were behavioral support and wheelchair repair/adaptation. A common theme for parents was the lack of access to services where providers accept Medicaid and where reimbursement rates were an issue. In both studies another common theme was the relative dissatisfaction with the coordination of care between providers for the parents of clients living at home and lack of knowledge of how to serve people with developmental disabilities when compared to individuals living in the community. When considering that 63% of DDD clients reside in the family home, these represent significant issues.

Target population data also yielded common themes. The target populations in the NCIS survey showed over 70% of respondents had communication challenges and from 30 - 77% had behavioral challenges. Similar to the results above, those living in the community reported higher proportions. About half of the severe/profound individuals and those requiring line-of-sight supervision had mobility challenges. Utilization of MAA services for high use clients were about 40% for dental and 75% for medical over a three year period. Finally, the small Supports Intensity Scale study indicates somewhat above average support needs overall for clients referred to the ATTC. The analysis of these target populations shows a multiple pattern of needs requiring careful coordination of services.

While demand information can help with showing the relative frequency of medical conditions, it is also important to examine the relative impact on these clients. With respect to communication challenges, there is evidence that approximately 40% of individuals with developmental disabilities have hearing impairment, a condition that directly inhibits their ability to communicate[11]. Wheelchair repair and customization is another example of a high impact service where approximately 30% of respondents in the NCIS study indicated mobility challenges. A reduction in mobility limits an individual's ability to access medical care, employment, and all aspects of activities for daily living.

Proposal

This proposal was based primarily upon the input of the retention of licensed professional services team whose direction was to develop and document a plan for the retention of some licensed professional services in the community should there be a decision to close Fircrest School. This proposal is an option based on input from the retention of licensed professional services work team, from staff of the Division of Developmental Disabilities, and from the Fircrest Downsizing/RHC Consolidation Project Support Unit.

The consultative model that follows provides selective licensed professional services within the developmental disabilities community, while building capacity for the community to provide additional specialized services for a vulnerable population. Scaled to align with Governor Locke's budget of December 2004, this model is a modified version of the original chapter on Licensed professional services. Other alternatives were developed prior to the publication of Governor Locke's proposed budget. These proposals are found in Appendix 3.2.D.

Consultative Model

The consultative model provides both direct and indirect services to clients with developmental disabilities. It would provide direct care for clients with dental, assistive technology, and wheelchair needs based on the findings from the demand portion of this report. Indirect services would include consulting, outreach, and building community resources. The focus of this model is to maximize statewide exposure and improve the quality of services to clients of DDD through consulting and outreach activities. A high level overview of this model is shown below in Table 6:

[11] Findings of a study at the Fircrest School, 2005. Audiologists examined medical records for current Fircrest School residents (N = 194), former residents now living in the community (N = 369), and community residents who had services at the Fircrest School (N = 80). Findings of this limited sample showed that 40% of Fircrest residents, 37% of former residents, and 50% of community referrals have hearing impairments. By comparison, approximately 10% of the general population has hearing impairment.

Table 6
High Level Overview of Consultative Model

MODEL	Direct Care Services*	FTE	Annual Number Served**	Biennial Cost	Annual Total Revenue**
Consultative	57%	9.0	3400	2.1 MM	0.25 MM

*Estimates of direct care for the Consultative model are for dental (80%), assistive technology (100%), and wheelchair (100%). Physician services, speech pathology, and occupational therapy are all approximately 20% direct care services.
**Descriptions of how estimates for Annual Number Served and Annual total Revenue are found in Appendices 3.2.E and 3.2.F, respectively. Total Annual Revenue is based on Medicaid reimbursement of which 50% is comprised of federal funding and the other 50% is state funding.

Description of Consultative Services

Direct Care

This proposal recommends the provision of direct care services in four areas: dental services, assistive technology, wheelchair adaptation and repair, and physician services. All clinical services would be overseen by the medical director who would also provide some medical care to clients and prescribe medications. Dental services would be provided in partnership with Dental Education in the Care of Persons with Disabilities (DECOD) and include both on-site and mobile services. The speech/language pathologist and occupational therapist would partner with the assistive technologist to provide augmentative communication solutions for clients. The occupational therapist would partner with the wheelchair technician to adapt and modify wheelchairs for seating and mobility positioning to improve client functioning.

A summary of the direct care services provided under the consultative model are as follows:

- Primary care
  - Assessment
  - Prescription
  - Referral
  - Home visits
- Dentistry
  - Emergent
  - General
  - Preventative
  - Sedation as needed
- Assistive Technology (AT)
  - Perform AT assessment
  - Identify appropriate devices
  - Assist with device acquisition
  - Train client and family in the use and programming of devices as needed
- Wheelchair
  - Repair
  - Modification and adaptation of equipment for individuals

Outreach and Building Community Resources

The major focus of this model is to improve the quality and access to services throughout Washington State. One approach is to identify providers throughout the state with an interest in serving individuals with developmental disabilities and to provide training and certification assistance. Another is to assist those who are currently providing those services (e.g., clinical, DDD case managers, and residential staff) by improving skills and access to resources that would help in providing services. A significant role for the professionals in this team would be to partner with existing programs in colleges and universities to educate professionals-in training about the special issues in treating individuals with developmental disabilities. Existing relationships with, for example, the University of Washington DECOD, family practice, internal medicine, Center for Human Development and Disability, and Center for Technology and Disability Studies are valuable sites for recruiting, developing residencies and internships. In addition, partnerships with community colleges such as Shoreline Community College who also have programs for dental hygiene and speech language pathology assistants are another potential way to build resources in the community.

The following is an overview of the outreach services for this model:

- Clinics and on-site coaching with professionals
    - Podiatry
    - Consultation and referral
    - Clinical Rx/Medication management
    - Vision
    - Psychiatric
    - Counseling
    - Behavior management
    - Nutrition
    - Communication
    - Adaptive Technology
    - Etc.
- Seminars, in-service presentations, workshops for families, DDD case managers and residential staff
- Recruitment of physicians, dentists, therapists and other providers
- Certification assistance for professionals in the care of individuals with developmental disabilities
- Mobile/on-site services
- Maintain a library of high and low tech augmentative communication and environmental control devices for training and evaluation purposes
- Build and maintain partnerships with the following:
    - Universities and colleges
    - Center on Human Development and Disability (CHDD)
    - Dental Education in the Care of Persons with Disabilities (DECOD)
    - Community clinics
    - Community mental health
    - Developmental disabilities councils
    - Residential providers
    - Advocacy groups
    - Institutions

Consulting and Statewide Access

Statewide access to these specialized services is provided through developing a network throughout the state, an operational website for resources and frequently asked questions, a listing of providers who are state certified to provide services to individuals with developmental disabilities, and a toll-free 1-800 number for questions. In addition, the providers would have mobile services to visit all regions of the state. Mobile services, clinics, demonstrations, and presentations would be coordinated by regional administrators with local service and residential providers in order to maximize impact. Statewide access to specialized information and consulting services would include the following:

- Consulting
    - Clinical providers in the community
    - Families
    - Residential providers
    - DDD Field Services staff
- 1-800 number assistance
- Website assistance
- Website resources links

Consultative Services Operations

The medical director would manage the operations, lead physician recruiting, and be integrally involved in recruiting other professionals. It would be the director's role to develop and support a plan to increase the capacity/willingness of medical providers to accept people with developmental disabilities living in the community. The director would be supported by an administrative assistant who would be responsible for the following:

- Maintaining clinical records
- Managing outsourced services
    - Medical transcription
    - Billing
    - Audiology
    - Physical therapy
    - Website management
- Producing training and education materials
- Scheduling staff
- Scheduling clinic appointments
- Maintaining client records

Comparison of Models

Table 7 below compares the proposal and four alternative models that were considered in this document based on the percentage of direct care, total staffing, estimates of the number of clients served, annual cost and annual revenue. Appendix 3.2.I contains a detailed description of the staffing differences between the models described in this document. When comparing these models, the compositions of the staff, staff roles, types of services, service reimbursement rates, and amount of outreach for staff members directly impact the number of DDD clients served and the estimated revenue. For example, the university

affiliation model is different from the consultative services model in that the model assumes a leaderless team with an emphasis on dental, assistive technology and wheelchair services. Differences in staffing for consultative services is one fewer dental assistant and 2.5 fewer FTEs for speech/language pathology, while adding a clinical director and support staff. The staffing differences between these models account for the major differences between the models.

Table 7
Comparison of All Models After Start-Up

MODEL	Direct Care Services*	FTE	Annual Number Served**	Annual Cost	Annual Total Revenue***
Consultative Services	57%	9.0	3400	1.1 MM	0.25 MM
Integrated	64%	28.2	4862	2.2 MM	0.8 MM
Reduced Client Services	76%	17.6	2756	1.6 MM	0.5 MM
Gap-Based	73%	22.1	3454	1.8 MM	0.6 MM
University Affiliation	56%	10.5	2067	.9 MM	0.4 MM

*Estimates for direct care are based on the total hours of direct care divided by the total hours available including support staff hours.
**These estimates show the number of unique clients based on projected number of procedures divided by an average of 7.3 procedures annually for each client except for the consultative model where estimates for dental, assistive technology and wheelchair were additive in that this is not an integrated service model.
***Total Annual Revenue is based on estimated Medicaid reimbursement; 50% is comprised of federal funding and the other 50% is State funding.

Other Comments

The comments below are directed toward issues elated to the implementation of this proposal should the legislature direct the closure of the Fircrest School. Under a decision to close the Fircrest School, the implementation of this proposal has assumed the following:

1. Consultive services staff would have the use of current Fircrest facilities through June 2007.
2. New facilities would be leased and staff moved beginning FY 2008.
3. Consultative services and collection of Medicare/Medicaid reimbursement would begin in January 2006.
4. Fircrest assistive technology, wheelchair, and dental equipment would be available for use by the licensed professionals. If equipment is not available, additional costs of $125,000 for dental, $50,000 for assistive technology, and $20,000 for wheelchair, and $7500 for physician would be required for start up.
5. Contracted services for medical transcription, billing, audiology, and physical therapy would require $80,000 annually

Requirements

The goals issuing from the requirements are long-range in nature and the complete accomplishment of these cannot be expected within a biennium. Consideration must be given to a staged implementation over several years with outcomes identified for each stage in order to meet all the goals. A more complete plan for the staged implementation of the proposal will present recommendations for their accomplishment. See the section on performance measures below for more information about potential outcome measures.

Direct Care

Billing Processes – Whether the billing is done internally or outsourced, internal processes would need to be developed to capture both diagnoses and treatment codes. This typically entails process development, staff training, and process monitoring. The proposal has made an assumption that Medicare/Medicaid reimbursements would begin to be collected in January of 2006. This would allow six months to develop internal processes and identify a billing vendor. A provision is made in the budget for software that would allow for either internal or external electronic billing.

Provider Certification – Providers would need to become Medicaid/Medicare certified in order to receive reimbursement. This process typically takes over two months to process the application and obtain a Medicare billing number. Provider identification for the consultative services team and certification would be conducted between July and December 2005.

Location and Space – There are many possibilities for the physical location for this team of professionals. The proposal has made an assumption that consultative services would be located at Fircrest School over the next biennium so that the licensed professional staff would be able to continue providing services to the Fircrest School residents while also providing services to community clients. Identifying clinic space and location to maximize access (multiple locations have been suggested by parents of individuals with developmental disabilities)

Client Screening – Clear guidelines would need to be developed for direct care access. Given limited direct care services, decisions concerning prioritization of access to these services would be crucial.

Coordination of Care – Provision is made for electronic medical records in order to most easily share client medical records with other community providers. The coordination of care was identified as a significant issue for clients in the demand assessment.

Consulting and Outreach

Consulting and outreach activities are a key element of the proposed model and is the primary method of recruiting and skill enhancement of community providers (both medical and residential). Effective consulting and outreach assumes that skill enhancement and easy access to information to help DDD clients would positively impact provider access. Issues regarding provider limits on Medicaid patients and reimbursement rates remain.

Performance Measures

A draft of potential outcome measures for implementation is found in Appendix 3.2.H. As mentioned previously, it is important to have clear measures of performance for each of the phases of implementation. Some suggestions for global performance measures include:

Phase 1 – Start-Up (Calendar Year 2006)

Budget – projected vs. actual

Revenue – projected vs. actual

Consulting and Outreach – number of professionals trained, site visits, and remote consults

Website – number of people visiting site

Establish baseline – providers serving DDD clients by region

Phase 2 – Transition (Calendar Year 2007-continuation of previous measures)

Consulting and Outreach – number of new providers by region, number of DDD providers certified

Client Quality of Life – identify or develop index

Client Satisfaction – identify or develop index

Phase 3 – Operational (Calendar Year 2008-continuation of previous measures)

Consulting and Outreach – professionals-in-training, fellowships, internships

Grants – dollar amount of grants

Appendices

3.2.A – Operating Budget Language
3.2.B – Definition of Services
3.2.C – Most Frequent Procedures
3.2.D – Other Models Considered
3.2.E – Estimates of Clients Served and Number of Clients Served and Number Procedures
3.2.F – Revenue Estimate Procedure
3.2.G – Alternative Model Budget and Procedures
3.2.H – Draft Outcomes
3.2.I – Staffing by Model
3.2.J – Other References

Appendix 3.2.A: Operating Budget Language

Language directing the downsizing of Fircrest School is shown below in full. The dollar amounts shown here are for the costs of managing the project, the cost associated with employee transition, and the costs of transporting clients from Fircrest School to their alternative placement. There are other sums included in the operating budget that are associated with downsizing Fircrest School in Section 205, Chapter 25, Laws of 2003, 1st Special Session for reduction in costs in the RHCs, community placements, and nursing programs.

> Sec. 211, Chapter 25, Laws of 2003, 1st Special Session. FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES – ADMINISTRATION AND SUPPORTING SERVICES PROGRAM
>
> General Fund-State Appropriation (FY 2004) $35,926,000
> General Fund-State Appropriation (FY 2005) $25,968,000
> General Fund-Federal Appropriation $45,752,000
> General Fund-Private/Local Appropriation $810,000
> TOTAL APPROPRIATION $108,456,000
>
> The appropriations in this section are subject to the following conditions and limitations:
> (1) $467,000 of the general fund-state appropriation for fiscal year 2004, $769,000 of the general fund-state appropriation for fiscal year 2005, and $1,236,000 of the general fund-federal appropriation are provided solely for transition costs associated with the downsizing effort at Fircrest School. The department shall organize the downsizing effort so as to minimize disruption to clients, employees, and the developmental disabilities program. The employees responsible for the downsizing effort shall report to the assistant secretary of the aging and disability services administration. Within the funds provided in this subsection, the department shall:
> (a) Determine appropriate ways to maximize federal reimbursement during the downsizing process;
> (b) Meet and confer with representatives of affected employees on how to assist employees who need help to relocate to other state jobs or to transition to private sector positions;
> (c) Review opportunities for state employees to continue caring for clients by assisting them in developing privately operated community residential alternatives. In conducting the review, the department will examine efforts in this area pursued by other states as part of institutional downsizing efforts;
> (d) Keep appropriate committees of the legislature apprised, through regular reports and periodic e-mail updates, of the development of and revisions to the work plan regarding this downsizing effort; and

(e) Provide a preliminary transition plan to the fiscal and policy committees of the legislature by January 1, 2004. ***The transition plan shall include recommendations on ways to continue to provide some of the licensed professional services offered at Fircrest School to clients being served in community settings.*** **(Emphasis added)**

Appendix 3.2.B: Definitions of Services

DDD Services

Professional Support Services: DDD funds the following professional support services for adult DDD clients supported by Community Residential Services: medical and dental services (for clients Medicaid-eligible), psychological Services (used to determine eligibility), professional evaluations (required by the criminal courts), counseling, nursing care, behavioral therapy, communication therapy, physical therapy, occupational therapy, instructional therapy, and other therapies approved by exception. DDD also funds professional support services for persons with developmental disabilities who live with their families.

Note: Client Services Data Base (CSDB) counts for medical/dental services include only those clients whose treatment was paid for by DDD. Those clients whose treatment was paid for by the Medical Assistance Administration are included in the MAA counts

Family Support Services: These services enable families to keep children with developmental disabilities at home. Family support services include respite care, attendant care, and transportation for attendants or family members. Some clients receiving family support services also receive the following services: nursing care, physical therapy, occupational therapy, instructional therapy, behavioral therapy, communication therapy, and counseling.

Personal Care Service: DDD provides personal care services to Medicaid-eligible children and adults. The major difference between children's and adult's personal care is in the interpretation of the level of need for specific personal care tasks. This service enables eligible individuals to remain in their community residences through the provision of semi-skilled maintenance or supportive services. These services can be provided in the person's own home, a licensed Adult family home (AFH), or an adult residential center (ARC).

DVR Services

Medical and Psychological Services: Agencies contracted by DVR provide medical or psychological evaluations needed to identify work potential and/or enhance job accessibility. Medical and psychological services include the purchase of adaptive devices, prostheses, eye glasses, and job site re-engineering

MAA Services

Dental Services: These include diagnostic, preventive, or corrective services provided by or under the supervision of an individual licensed to practice dentistry or dental surgery.

Hospital Inpatient Care: Hospital inpatient care includes care and treatment to clients admitted to stay at a facility under the direction of a physician or dentist. A licensed or formally approved hospital furnishes these services. This program includes emergency room services to clients admitted through the emergency room to an inpatient stay. Hospital Inpatient care includes room and board and other ancillary services such as drugs, laboratory, and radiology.

Hospital Outpatient Care: A licensed or approved hospital provides hospital outpatient care to clients treated, but not admitted to stay, at the facility.

Other Medical Services: Other medical services includes durable medical equipment, home health care, hospice care, maternity case management, medically necessary transportation, optometrists, opticians and eyeglasses, chiropractic care, oxygen, hearing aids, and a variety of other services that represent a small proportion of MAA expenditures.

Physician Service: A provider of Physician Services is, or is under the personal supervision of, an individual licensed to practice medicine or osteopathy. Providers furnish physician services in the physician's office, the client's home, a hospital, a nursing home, or a clinic. Physician services include primary care case management.

Prescription Drugs: These include simple or compound substances or mixtures prescribed by a physician or other licensed practitioner and dispensed by licensed pharmacists or other authorized practitioners, with no adjustment for drug rebate.

Managed Health Care Payments: Managed health care payments are fixed monthly premiums paid on a per client basis to managed health care providers. In return for the payment, a managed health care provider makes a range of services available to the client. The one-time payment is independent of the client's use of those services and replaces the traditional fee-for-service arrangement. Health maintenance organizations, which provide services through staff physicians; or health insuring organizations, which contract with primary care physicians to provide services, administer managed health care plans.

Appendix 3.2.C: Most Frequent Procedures

CPT	3 Year Frequency	Type Service	Description
99213	9389	Medical	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity.
D4341	4506	Dental	Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth spaces, per quadrant
99214	3915	Medical	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity.
D0120	3228	Dental	Periodic oral evaluation
99212	1761	Medical	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history -- a problem focused examination -- straightforward medical decision making
D1110	1482	Dental	Prophylaxis – Adult
D0220	1107	Dental	Intraoral periapical – single, first film
D0274	1067	Dental	Bitewings – 4 films
90806	1048	Psych	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes.
92507	1005	Speech	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
D0140	955	Dental	Limited oral evaluation
90804	909	Psych	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes.
90805	832	Psych	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face to face with the patient; with medical evaluation and management services.
97110	831	PT	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
90853	791	Psych	Group psychotherapy (other than of a multiple-family group)
D0150	784	Dental	Amalgam – 2 surfaces, primary or permanent
D0230	755	Dental	Intraoral periapical – each additional film
D2140	741	Dental	Amalgam – 1 surface, primary or permanent
D2150	715	Dental	Amalgam – 2 surfaces, primary or permanent
99211	682	Medical	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising
D9920	680	Dental	Behavior management - Involves a patient whose documented behavior requires the assistance of one additional dental professional staff to protect the patient from self-injury while treatment is rendered.
99215 ~80%	565	Medical	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history -- a comprehensive examination -- medical decision making of high complexity.

CPT	3 Year Frequency	Type Service	Description
97530	543	PT	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
D2330	471	Dental	Resin-based composite – 1 surface, anterior
D0272	399	Dental	Bitewings – 2 films
99203	395	Medical	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history -- a detailed examination -- and medical decision making of low complexity.
D0330	381	Dental	Panoramic film
97140	363	PT	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
D7210	360	Dental	Surgical removal of erupted tooth
D2331	345	Dental	Resin-based composite – 2 surfaces, anterior
D2160	328	Dental	Amalgam - three surfaces ,primary or permanent
99202	314	Medical	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history -- an expanded problem focused examination -- and straightforward medical decision making.
99312	283	Medical	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient
99311	253	Medical	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient,
D9110 ~90%	244	Dental	Palliative (emergency) treatment of dental pain – minor procedure
D2332	232	Dental	Resin-based composite – 3 surfaces, anterior
97112	231	PT	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
99244	221	Medical	Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity
99243	217	Medical	Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity.
97035	196	PT	Application of a modality to one or more areas; ultrasound, each 15 minutes
99204	191	Medical	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.
D1204	181	Dental	Topical application of fluoride gel or varnish
D2161	178	Dental	Amalgam – 4 or more surfaces, primary or permanent
D2335	176	Dental	Resin-based composite – 4 or more surfaces, anterior
92508	169	Speech	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals
90807	167	Psych	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
D9410	161	Dental	House/extended care facility call
D0210 ~95%	142	Dental	Intraoral – complete series (including bitewings)

Appendix 3.2.D: Other Models Considered

Integrated Services in a Clinic Setting

There are a growing number of persons with developmental disabilities leaving institutions and entering community living with a complex array of medical conditions and disabilities. No single professional is able to provide all facets of such individuals' therapy and health care needs. There is a promising practice identified by MEDSTAT[12], Village Integrated Service Agency, a program of the Mental Health Association in Los Angeles County. This service integrates all components of mental health care including treatment, rehabilitation, family and community support, and self-help. It tailors services to each individual's needs and has become a national model and a training ground to help others replicate its approach.

The integrated model proposed by the work team is based on such "best practices" and the notion of "one-stop shopping" for DDD clients who are more medically complex and who may have co-existing conditions. Integration for the purpose of this proposal is based on high coordination of services that maximizes outcomes. The intent of the integrated model is to provide some professional services through a clinic setting with the goal of integrating its services within the clinic and into the existing healthcare infrastructure**.**

The clinic as proposed would provide services to individuals with developmental disabilities who are otherwise unable to obtain them. This may be due any combination of severity, complexity or chronicity of their medical or behavioral condition and/or to financial barriers, when the lack of professional services creates potential barriers to self-determination and independence in community life. The proposal incorporates multiple goals including:

1. *Direct Care* – provide on-going care, comprehensive assessments, and treatment planning to individuals with developmental disabilities
2. *Consulting and Outreach* – training and consultation with health care professionals, support staff serving clients with developmental disabilities, and family members regarding the special challenges presented in treating persons with developmental disabilities
3. *Building Community Resources* – specialized training opportunities to students of health care in local colleges and universities
4. *Statewide Access* – begin the process of extending the services above to all parts of the State of Washington

[12]Amy Leventhal Stern, Ph.D. *Promising Practices In Home And Community- Based Services California – Village Integrated Service Agency* Issue: Comprehensive, Individualized Services for People with Serious Mental Illnesses Through a Single Provider**. Note:** This report is one of a series of reports by The MEDSTAT Group for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series will be available online at CMS'website, http://www.cms.gov. Information about the Village is available on the Internet at http://www.village-isa.org

The following is a summary of the clinical services proposed for the integrated model[13]:

- **Medical** – primary care, diagnosis, and referral to appropriate specialties
- **Dental** – emergent and general dentistry including preventative care and sedation as needed
- **Speech Pathology** – diagnosis and treatment of functional and organic speech defects and disorders such as stuttering and dysphasia (swallowing disorders).
- **Assistive Technology** – services include directly assisting an individual with a disability in the selection, acquisition, or use of an assistive technology device.
- **Audiology** – identify and measure hearing impairments and related disorders using a variety of tests and procedures.
- **Behavioral** – individual psychological evaluation (including psychological and neurological testing), development of positive behavior support plans (BSP), education to individuals with developmental disabilities as well as family and caregivers, and provide direct therapy when indicated. A special emphasis is on behavior that interferes with needed rehabilitative, residential or vocational services. The goal is to reduce challenging behavior and/or increase the individual's positive engagement with his or her environment.
- **Physical Therapy** – services to reduce disability and pain, restore function, promote healing, and adapt to permanent disability.
- **Occupational Therapy** – focuses on functional performance through the therapeutic use of self-care, work and play activities to increase independent function, enhance development, minimize disability, and enhance the quality of life. For the proposed model this also includes wheelchair adaptation and repair.

Clients Served

Using the model above, the number of clients served and number of services offered was calculated for each area of clinical service. Table 7 below shows the best estimate of the number of unique clients by service area. Appendix 3.2.E contains an explanation of the procedure used to estimate the number of unique clients. It should be noted that some clients would be accessing more than one clinical service in a year so these columns should not be totaled.

Table 7
Estimates of the Number of Unique Clients Served for Each Service Area

Service	Jul-Dec 05	Jan-Jun 06	Jul-Dec 06	Jan-Jun 07	Jul-Dec 07	Jan-Jun 08	Jul-Dec 08	Jan-Jun 09
Assistive Technology	0	36	120	216	240	240	240	240
Audiology	0	98	325	585	650	650	650	650
Behavioral	0	90	300	540	600	600	600	600
Dental	0	120	400	720	800	800	800	800
Medical	0	221	735	1324	1471	1471	1471	1471
OT/Wheelchair	0	209	695	1251	1390	1390	1390	1390
PT	0	95	317	570	633	633	633	633
Speech Pathology	0	342	1140	2052	2280	2280	2280	2280

[13] In addition, the proposal includes business office services to include – office management, scheduling, billing, medical records, reception, medical transcription, secretarial services.

Table 8 below includes the estimates from the clinical team members for the number of clinical procedures that can be provided within their respective time frames assuming that about 20% of their time would be involved in Consulting and Outreach. During calendar years 2001-2003, clients averaged 7.2 procedures annually. The average unique clients during each six month period are reflected in the final row.

Table 8
Estimates of the Number of Procedures for Each Service Area
And Number of Unique Clients Undifferentiated by Procedure

Service	Jul-Dec 05	Jan-Jun 06	Jul-Dec 06	Jan-Jun 07	Jul-Dec 07	Jan-Jun 08	Jul-Dec 08	Jan-Jun 09
Assistive Technology	0	36	120	216	240	240	240	240
Audiology	0	97.5	325	585	650	650	650	650
Behavioral	0	144	480	864	960	960	960	960
Dental	0	432	1440	2592	2880	2880	2880	2880
Medical	0	375	1250	2250	2500	2500	2500	2500
OT/Wheelchair	0	208.5	695	1251	1390	1390	1390	1390
PT	0	285	950	1710	1900	1900	1900	1900
Speech Pathology	0	427.5	1425	2565	2850	2850	2850	2850
TOTAL	**0**	**2005.5**	**6685**	**12033**	**13370**	**13370**	**13370**	**13370**
Avg Unique Clients	**0**	**275**	**916**	**1648**	**1832**	**1832**	**1832**	**1832**

Budget

The preliminary budget for this model includes the following areas: proposed staffing, estimated costs, and projected revenue.

Proposed Staffing

The staffing for the integrated model is based on a start date of January 2006 and is graduated over the 2005-2007 Biennium to include increasing amounts of community services as Fircrest School residents leave the institution. The proposal is fully implemented when all residents have vacated Fircrest School by the end of February 2007. Table 9 below shows the staffing levels for the next two biennia.

Table 9
Staffing for Integrated Services Model
2005-2009 Biennia

FTE	FY 2006	FY 2007	B 05-07	FY 2008	FY 2009	B 07-09
Dental	2.0	4.0	3.0	4.0	4.0	4.0
Speech Pathology	2.8	5.5	4.1	5.5	5.5	5.5
Medical	1.5	3.0	2.3	3.0	3.0	3.0
Audiology	0.6	1.2	0.9	1.2	1.2	1.2
Assistive Technology	0.3	0.5	0.4	0.5	0.5	0.5
Physical Therapy	1.5	3.0	2.3	3.0	3.0	3.0
Occupational Therapy	2.5	5.0	3.8	5.0	5.0	5.0
Psychology	1.0	2.0	1.5	2.0	2.0	2.0
Business Office	2.0	4.0	3.0	4.0	4.0	4.0
TOTAL FTE	**14.1**	**28.2**	**21.2**	**28.2**	**28.2**	**28.2**

Estimated Costs

Costs for this proposal include moving, new equipment, lease, salaries, benefits and all other costs for the proposed model. Table 10 shows the total estimated costs by year and biennia.

Table 10
Costs for Integrated Services Model
2005-2009 Biennia

Service	FY 2006	FY 2007	B 05-07	FY 2008	FY 2009	B 07-09
Dental	$304,470	$430,740	$735,211	$379,140	$379,140	$758,281
Speech Pathology	$192,866	$428,832	$621,698	$434,631	$434,631	$869,262
Medical	$214,672	$417,544	$632,216	$378,844	$378,844	$757,688
Audiology	$105,658	$100,657	$206,315	$97,476	$97,476	$194,952
Assistive Technology	$27,681	$60,112	$87,792	$51,161	$51,161	$102,322
Physical Therapy	$133,761	$259,523	$393,284	$220,823	$220,823	$441,646
Occupational Therapy	$170,963	$416,926	$587,889	$348,987	$348,987	$697,974
Psych	$89,665	$215,729	$305,394	$189,929	$189,929	$379,859
Business Office	$243,204	$297,504	$540,707	$245,904	$245,904	$491,807
TOTAL DOLLARS	**$1,482,940**	**$2,627,567**	**$4,110,506**	**$2,346,895**	**$2,346,895**	**$4,693,791**

Projected Revenue

Revenue estimates for the model were calculated as shown in Appendix 3.2.F. These estimates were based on the type of service and the estimated capacity to provide these services. Table 11 below shows the results of this estimation procedure. The column of federal match is the best estimate of the monies that would be captured to offset costs.

Table 11
Estimated Annual Revenue When Integrated Services is Fully Implemented

Service	TOTAL ANNUAL REIMBURSEMENT FROM MAA	FEDERAL MATCH @ 50%
Assistive Technology*	0	0
Audiology**	-	-
Behavioral	$41,081.97	$20,540.99
Dental	$177,367.19	$88,683.59
Medical	$185,749.17	$92,874.58
OT/Wheelchair***	$72,117.83	$36,058.92
PT	$105,614.94	$52,807.47
Speech Pathology	$265,226.94	$132,613.47
TOTAL	**$847,158.04**	**$423,579.02**

* Not currently reimbursed
** Combined with Speech Pathology
*** Wheelchair not reimbursed

All the models below share common goals and requirements albeit in different proportions based on staffing and services provided. Table 12 below is a direct comparison of the models based on the amount of direct care, FTE requirements, number of clients served, cost, and estimated total annual revenue. More complete information on budget (staffing, cost, revenue) and number of clients served is found in Appendix 3.2.G.

Table 12
Comparison of Alternative Models After Start Up

MODEL	Direct Care Services	FTE	Annual Number Served*	Cost	Total Annual Revenue**
Integrated	64%	28.2	4862	2.2 MM	.8MM
Reduced Client Services	76%	17.6	2756	1.6 MM	.5MM
Gap-Based	73%	22.1	3454	1.8 MM	.6MM
University Affiliation	56%	10.5	2067	.9 MM	.4MM

*These estimates show the number of unique clients based on projected number of procedures divided by an average of 7.3 procedures annually for each client.
**Total Annual Revenue is based on Medicaid reimbursement of which 50% is comprised of federal funding and the other 50% is State funding.

Reduced Client Services

This model is similar to the integrated service model described above. The major difference is in the number of professionals and the number of clients that can be served while still emphasizing the integration of services, providing direct services, consulting and outreach. In this model medical, dental, behavioral, audiology and support services are maintained, but minimized. The role of the physician is as a clinic director as well as providing direct care, consulting, and outreach, but without the support of a medical assistant, nurse practitioner, medical assistant to assist with the direct care. Dental services are likewise reduced to providing direct care primarily emergency in nature. Finally, the level of support services is also reduced requiring professional staff to manage more of these tasks themselves.

Gap-Based

The gap-based model emphasizes the services identified in the demand analysis while still maintaining service integration, consulting, outreach and coordination for clients. It is proposed as a clinic-based service model and more closely mirrors the demand for dental, behavioral, and communication services. It also increases the transition manager position to a full FTE in order to assist with the implementation of operational systems.

University Affiliation

The university affiliation model is based on existing relationships between the staff at the Fircrest School and the University of Washington, University of Kansas, and Shoreline Community College. More specifically, the University of Washington has active programs for people with developmental disabilities including: Center on Human Development and Disability (CHDD), Dental Education in the Care of Persons with Developmental Disabilities (DECOD), Tacoma Family Medicine, and Rehabilitation Department Assistive Technology Team. Shoreline Community College also has active programs for paraprofessionals such as speech language pathology assistants. University affiliation has been identified as being important to recruiting and identification of providers for persons with developmental disabilities. Internships with skilled providers have been a major way of educating and increasing the resource base of providers of services for people with developmental disabilities.

This model continues direct care services for dental, communication (speech pathology and assistive technology), and wheelchair repair/adaptation. These services are intended to become a part of the University of Washington and/or Shoreline Community College utilizing their existing infrastructure to provide direct care, consulting, outreach and to build community resources.

Appendix 3.2.E: Estimates of Number of Clients Served

To estimate the number of clients served, the following steps were used:

1. Experience from calendar years 2001 -2003 MAA data
   All procedures paid for by MAA during calendar years 2001 – 2003 for adult DDD clients in King, Snohomish, and Pierce counties were compared to the number of clients served during this same period. CPT codes identified by the RLPS team as being relevant to the adult developmental disabilities population were used to create the data base. The ratio of procedures provided to the number of clients served overall (undifferentiated by type of service) for these years were 6.4, 6.3, and 7.3 respectively. The expectation is that these ratios are likely to continue to increase in the future. Using a ratio of 7.3 procedures per adult client for the next two biennium, the estimate for the total number of clients served for the proposed model for each FY is as follows:

   a. FY 2005 = 2005/7.3 = 275
   b. FY 2006 = 18718/7.3 = 2564
   c. FY 2007 = 26740/7.3 = 3663
   d. FY 2008 = 26740/7.3 = 3663

2. The ratios by service provided was similarly calculated from MAA data and compared against estimates of capacity. The ratios used to calculate the estimates of number of unique clients for each service are shown in the table below:

	# Annual Procedures/Client
Assistive Technology	1
Audiology	1
Behavioral	1.6
Dental	3.6
Medical	1.7
OT/Wheelchair	1
PT	3
Speech Pathology	1.25

Appendix 3.2.F: Revenue Estimate Procedures

ASSUMPTIONS:

1. CPT codes identified by team members will remain about the same over the next two biennia.
2. Federal reimbursement rates will remain approximately the same over the next two biennia.
3. The relative frequency of the procedures will remain the same over the next two biennia.

ESTIMATION PROCESS:

1. CPT codes for each of the service areas were generated for services to be provided.
2. Complete MAA procedure and reimbursement data from 1/12/1996 through 10/21/2004 was obtained for all adult clients of DDD who reside in the community within Snohomish, King, and Pierce counties. Only data from FY2001 – FY2003 was used due to changes in reimbursements for dental services beginning in 2001 and to obtain complete billing information since providers have up to 12 months to submit a bill. Revenue estimates, therefore, are based on three years of experience of MAA reimbursements for relevant CPT codes.
3. Reimbursements for each of the actual CPT codes were based on 2003 reimbursement rates. No attempt was made to estimate changes in reimbursement over the next two biennia for any of these procedures. It should be noted, however, that reimbursements for dental procedures are under review and new rates are expected to go into effect mid-2005.
4. Estimates of the number of procedures that could be provided for each service area were determined by team members representing those clinical specialties.
5. The average reimbursement for the CPT codes for each service were obtained from the most recent (2003) MAA data where possible, otherwise they were obtained from previous years if the procedure wasn't performed in 2003.
6. Estimates of reimbursements were weighted by the relative frequency that the procedures occurred over the three year period. The formula used is as follows: ((number of specific procedure by CPT code for 2001+2002+2003)/(total number of procedures for all CPT codes within a service area for 2001+2002+2003))
7. The final estimates of revenue by clinical area were determined as follows: (estimated total annual number of procedures/year/specialty)*(Relative frequency of procedures based on 3 years experience)*(average reimbursement during 2003 calendar year per CPT code). When summed, this estimate provides an estimate of the total annual MAA reimbursement including both state and federal contributions. Federal contributions constitute approximately 50% of total MAA reimbursements.

Appendix 3.2.G: Alternative Models Cost, Revenue, Number of Clients Served and Number of Procedures

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Budget

	TOTAL ANNUAL COSTS WHEN FULLY IMPLEMENTED*			
Service	**Integrated**	**Reduced**	**Gap Based**	**University Affiliation**
Assistive Technology	$51,161.53	$51,161.53	$51,161.53	$51,161.53
Audiology	$97,476.85	$52,613.43	$52,613.43	
Behavioral	$189,929.32	$96,264.66	$189,929.32	
Dental	$379,140.44	$112,443.69	$379,140.44	$379,140.44
Medical	$378,843.94	$202,910.00	$202,910.00	
OT/Wheelchair	$348,987.44	$176,749.38	$176,749.38	$50,336.70
PT	$220,822.78	$220,822.78	$220,822.78	
Speech Pathology	$434,631.94	$394,887.76	$394,887.76	$394,887.76
Support Services	$245,903.52	$147,302.52	$196,089.02	
TOTAL	**$2,346,897.76**	**$1,455,155.75**	**$1,864,303.66**	**$875,526.43**

*Does not reflect start up costs during first biennium.

Revenue

	TOTAL ANNUAL REVENUE WHEN FULLY IMPLEMENTED			
Service	**Integrated**	**Reduced**	**Gap Based**	**University Affiliation**
Assistive Technology*	$0.00	$0.00	$0.00	$0.00
Audiology**	$0.00	$0.00	$0.00	$0.00
Behavioral	$41,081.97	$20,540.99	$41,081.97	$0.00
Dental	$177,367.19	$88,683.59	$177,367.19	$177,367.19
Medical	$185,749.17	$104,019.53	$104,019.53	$0.00
OT/Wheelchair***	$72,117.83	$24,073.87	$24,073.87	$0.00
PT	$105,614.94	$34,741.76	$34,741.76	$0.00
Speech Pathology	$265,226.94	$238,704.24	$238,704.24	$238,704.24
TOTAL	**$847,158.04**	**$510,763.98**	**$619,988.56**	**$416,071.43**

* Not currently reimbursed
** Combined with Speech Pathology
*** Wheelchair not reimbursed

Clients Served

	ANNUAL CLIENTS SERVED BY SERVICE WHEN FULLY IMPLEMENTED*			
	Integrated	**Reduced**	**Gap**	**University**
Assistive Technology	480	480	480	480
Audiology	1300	650	650	0
Behavioral	1200	600	1200	0
Dental	1600	800	1600	1600
Medical	2941	1694	1694	0
OT/Wheelchair	2780	928	928	0
PT	1267	417	417	0
Speech Pathology	4560	4104	4104	4104

*These columns should not be totaled since clients use multiple procedures annually.

Number of Procedures

	ANNUAL NUMBER OF PROCEDURES AND UNIQUE CLIENTS WHEN FULLY IMPLEMENTED			
	Integrated	**Reduced**	**Gap**	**University**
Assistive Technology	480	480	480	480
Audiology	1300	650	650	0
Behavioral	1920	960	1920	0
Dental	5760	2880	5760	5760
Medical	5000	2880	2880	0
OT/Wheelchair	2780	928	928	0
PT	3800	1250	1250	0
Speech Pathology	5700	5130	5130	5130
TOTAL PROCEDURES	**26740**	**15158**	**18998**	**11370**
AVE UNIQUE CLIENTS	**3663**	**2076**	**2602**	**1558**

Appendix 3.2.H: Draft Outcome Measures

Topic	Measure	Data Source	Report Frequency
Direct Care			
Client Success	Client Satisfaction – model after Speech Path (also staff)	Survey	Annual
	Visit Evaluation 1=one-visit solution 2=still seeing regularly 3= 4=referred w/contacts 5=referred out	Rating	Annual
	Before/after within-subject design	Critical Incidents DB	Quarterly
	Quality of Life - Home adaptation, SIS, CARE, other standardized scales	Regional Support Report	Annual
	Clients Seen - Count	Create DB	Quarterly
	Client goal attainment scale	Rating	
	Progress toward Surgeon General's Goals	Rating?	Annual
Demographic	Comparison w/ General DDD Population - Type and severity of cases	Regional Data MAA & SSPS Data Bases	Annual
Economic	Reimbursement/costs	MAA, SSPS, Critical Incident Data Bases	Annual
	Societal and individual costs		Annual
	Reduced-avoided costs		Annual
	Contracts with other agencies		Annual
	OP vs. IP $$ spent on DDD clients	Ratio based on MAA & SSPS Data Bases	Annual
	Preventative vs. urgent care for all services (Dental, Medical, Therapies)		Annual
			Quarterly Accomplishments Newsletter Web-Site

Topic	Measure	Data Source	Frequency
Outreach			
Volume	Number of classes, people seen	Attendance Sheets	Quarterly
	Time spent consulting, site visits – phone and in person	Time Sheets	
	Publications - Number of published reports	Records	Annual
	Number and amount of grants		
Interns	Number of interns or grads and time of involvement, use grad student to set up research protocols and define populations, look for partnerships with CHDD and other research-based organizations	Time Sheets	Annual
Provider Participation	Number of providers serving DDD	Regional Data MAA & SSPS Data Bases	Annual
	Number of DDD clients seen		
	Improvement in direct care		

Appendix 3.2.I: Staffing by Model

STAFFING FOR LICENSED PROFESSIONAL SERVICES MODELS

	POSITION	Consultative Services	Integrated Services	Reduced Staff	Gap Based	University Affiliation
Medical	Physician	1.0	1.0	1.0	1.0	
	Nurse Practitioner		1.0			
	Nursing Asst. Cert.		1.0			
Audio	Audiologist		1.2	0.6	0.6	
Dental	Dentist	3.0	1.0	0.5	1.0	1.0
	Dental Hygienist		1.0		1.0	1.0
	Dental Assistant		2.0	0.5	2.0	2.0
Behavioral	Psychologists 4-5-6		2.0	1.0	2.0	
Speech	Speech Pathologist	4.0**	4.5	4.0	4.0	4.0
	SP Therapy Aide		1.0	1.0	1.0	1.0
	Assistive Technologist		0.5	0.5	0.5	0.5
OT	OT Supervisor		1.0			
	OT		2.0	1.0	1.0	
	Certified OT Asst.		1.0	1.0	1.0	
	Wheelchair Tech		1.0	1.0	1.0	1.0
PT	Physical Therapist		1.0	1.0	1.0	
	PT Assistant		1.0	1.0	1.0	
	PT Aide		1.0	1.0	1.0	
Support	Recept/Sched/Sec		1.0	1.0	1.0	
	Transition Manager		1.0	0.5	1.0	
	Medical Asst./Pt. Svcs		1.0			
	ART/Med.Transcrip.		1.0	1.0	1.0	
	Senior Office Asst.	1.0				
	Total	**9.0**	**28.2**	**17.6**	**22.1**	**10.5**

*Assistive Technologist/Wheelchair combined
**Team to work together to provide communication and wheelchair services.

Appendix 3.2.J: Other References

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